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	085002	A. BUILDING _____ B. WING _____	05/03/2017

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from April 25, 2017 through May 3, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 140. The Stage 2 survey sample size was 27. Abbreviations/definitions used in this report are as follows: CAA- Care Area Assessment(s)/Identifies potential problem areas which may or may not require care planning; MDS- Minimum Data Set/Standardized assessment tool used in long term care facilities; NHA - Nursing Home Administrator; DON - Director of Nursing; RNAC- Registered Nurse Assessment Coordinator; RN - Registered Nurse; CNA-certified nursing assistant; LPN - Licensed Practical Nurse; NP - Nurse Practitioner; DLTCRP-Division of Long Term Care Residents Protection; Frequently Incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period; Incontinence - loss of control of bladder &/or bowel function; mcg - microgram; mg - milligram; Omeprazole (Prilosec)- medication used to decrease stomach acid; Root Cause Analysis- method of problem solving used for identifying the root causes of faults or	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/25/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

problems;
R/T-Related to;
Psych (Psychiatrist) - Medical doctor who specializes in mental health;
dycem--non slip and anti slip material such as mats, self-adhesive;
Restorative ambulation- maintaining and enhancing the resident's ability to ambulate;
helmet- a hard or padded protective hat;
U (u)- units;
Vitamin D2 (Ergocalciferol) - plant based form of Vitamin D; less absorbable and less potent in raising and maintaining Vitamin D levels than Vitamin D3;
Vitamin D3 (Cholecalciferol)- natural form of Vitamin D that is more readily absorbed than Vitamin D2 and is more efficient in raising and maintaining Vitamin D levels than Vitamin D2;
Egress mattress-foam mattress that gives patient extra support when getting out of bed;
Periorbital - around the eyes;
occiput - back part of the head;
palpation - an act of feeling and touching by pressure of hands or fingers to the surface of the body;
alert x2 - to person and place;
+ - positive;
ROM - Range of Motion;
Parietal area - forming the wall of a body part;
cognitive - conscious mental activity such as thinking, understanding and learning;
Neuro check - used to assess an individual's level of consciousness;
WNL - within normal limits;
PRN - as needed;
hematoma - localized collection of blood outside the blood vessels due to trauma or disease;
verbalized- express, speak;
ER - Emergency Room;

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F 000	Continued From page 2 CT Scan- imaging machine rotates around patient's while shooting X-ray beam toward them-creates detailed images of the body; PT-physical therapy; OT-occupational therapy; Haldol-medication to decrease the excitement of the brain; POC - Plan of Care.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect,	F 225		6/19/17

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F 225	Continued From page 3 exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that 3 incidents involving serious injuries/injuries sustained from unwitnessed falls that required	F 225	1. All incidents (events) were reviewed by the DON and discussed with the staff involved. 2. All events occurring in the past 2	

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F 225	Continued From page 4 transfers to acute care (hospital), for 1 resident (R27) out of 27 Stage 2 sampled, one (1) incident was not immediately reported to the DLTCRP (Division of Long Term Care Residents Protection),and all three (3) incidents were not thoroughly investigated . Findings include: Review of R27's clinical record revealed the following: 1.a. 1/07/17 at 13:11 (1:11 PM) -Nursing Event Report stated: Description: Un-witnessed fall in hallway. Summary of event: Resident discovered sitting in hallway on buttocks holding bleeding mouth. 1/07/17 at 1:24 PM -Nursing progress note stated that the witness noticed resident sitting on the floor on her buttocks, holding bleeding mouth in the hallway. R27's cognitive status was alert x 2 (person and place) with confusion. R27 sustained a laceration (cut) to her exterior lower lip and internal lower lip. Neuro checks WNL. Resident was given PRN Tylenol for pain with severity of 5 out 10. NP ordered to send R27 to ER for evaluation and treatment. Left the facility at 1:35 PM. 1/7/17 at 17:10 (5:10 PM)-Resident returned to the facility from the hospital with internal and external suture on the bottom lip and swollen with purple bruise noted to left lower shin. CT of the head, neck and face with negative result. Review of records revealed that the facility lacked documentation that this incident was immediately reported to the DLTCRP and was not thoroughly investigated.	F 225	months have been reviewed for completeness of investigation and appropriate reporting to DLTCRP. 3. (a) All nurses will receive additional training on thorough investigating and reporting of incidents by the Staff Developer. (b) The DON/Designee will review all events daily to ensure thorough investigating and appropriate reporting. An incident tracking system will be put into place to ensure all events have appropriate witness statements, assessments, MD/family notification and care plan revisions. 4. The tracking system will continue until events have been investigated and reported with 100% compliance for 2 consecutive quarters. The findings will be reviewed by the IDT at the monthly QA meeting.	

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F 225	Continued From page 5 This finding was reviewed with E1 (Administrator) and E2 (DON) on 5/2/17 at 1:30 PM. 1.b. 4/3/17 at 22:41 (10:41 PM) Nurse's progress note stated that E8 (LPN) heard a thud and saw patient (R27) on the floor. On assessment patient was found to sustain hematoma on her occiput area, and patient verbalized pain on palpation. NP was notified and ordered to send the patient to the ER for further evaluation and treatment. R27 left for the hospital at 10:45 PM. 4/3/17 at 23:35 (11:35 PM) the incident was immediately reported to the DLTCRP. 4/7/17 -The facility's result of the investigation was submitted to the DLTCRP. The facility's follow up/or result of the investigation reported that it was followed up in the facility's fall committee and there was no evidence of abuse or neglect. However, review of the facility's investigation of the incident revealed that it was not investigated thoroughly. For example, there were no evidence that the staff who provided care to R27 prior to these unwitnessed fall were interviewed. On 5/3/17 at 12:30 PM- the facility submitted to the surveyor, copies of interviews/written statements from E8 (LPN), E9 (LPN) and E12 (CNA) conducted by the facility during the survey on/dated 5/2/17 for the 4/3/17 incident of R27's unwitnessed fall with injuries. 1.c. 4/11/17 at 03:30-Nurse's progress note stated that Resident was found on the floor in her room by her dresser at 3:20 AM after her roommate came to the nurse's station. Resident	F 225		

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F 225	Continued From page 6 sustained injuries such as laceration above her right eye and a bleeding nose and ecchymotic area to her right knee. R27 was unable to tell how she fell or what she was attempting to do. NP ordered to send R27 to the hospital ER for evaluation and treatment. 4/11/17 at 9:59 AM -Incident report was submitted to the DLTCRP. 4/12/17at 22:45 (10:45 PM) Nurse's Progress note stated that R27 returned to the facility with a lacerated wound on her right eyebrow, hematoma to right forehead, right and left Periorbital sides of her nose and right upper lip, hematoma to her right shoulder, left and right forearm, left elbow, right knee and left lower extremity. 4/13/17 follow up/result of investigation was submitted to the DLTCRP. The facility's follow up/or result of the investigation report stated that Resident returned from the hospital with non-displaced nasal bone fracture. POC updated upon return. No evidence of abuse or neglect. However, review of the facility's investigation of the incident revealed that the facility has no documented evidence that the incident was thoroughly investigated. For example, there was no evidence that the CNA and/or CNAs who provided care to R27 prior to these unwitnessed fall were interviewed and including the roommate who reported the incident. Findings were reviewed with E1 (Administrator) and E2 (DON) on 5/2/17 at 1:30 PM.	F 225		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		6/19/17

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F 253	Continued From page 7 (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide the necessary housekeeping and maintenance services for 2 rooms (Greenville 116G and Westover 318A) out of 31 rooms surveyed. Findings include: The following was found during the environmental tour on 5/1/17 from 1:30 PM to 2:30 PM as well as during stage 1: Greenville 116G - The fall mat on the left side of the bed was dirty; - The bathroom ceiling tile to the right of the entrance was stained; Westover 318A - The armrest covers of the toilet safety rails were frayed, exposing the metal frame. Findings were reviewed and confirmed with E10 (Facility Maintenance Director) and E11 (Director of Housekeeping) on May 1, 2017 at approximately 2:30 PM. Findings were reviewed on 5/3/17 at approximately 3:45 PM with E1 (NHA) and E2 (DON).	F 253	1. Discussion was held on findings with Maintenance Director, Environmental Director and Administrator at time of exit. Maintenance Director and Environmental Director immediately corrected deficiencies related to Room 116 and 318 during Survey. 2. An audit of all resident rooms was conducted to identify all needs in relation to findings during survey by Maintenance and Environmental. Corrections will be made accordingly as deficiencies are found in other resident rooms. 3. The Maintenance Director will add additional items identified during survey to monthly audit of resident bathrooms. In addition, this audit will be added to the TELS system for tracking. Environmental Director will inservice staff on daily resident room cleaning instructions to include attention to floor mats. 4. A sample size audit of 25% of the facility resident bathroom areas to identify disrepair will be conducted monthly by Maintenance Director and/or Designee. Environmental Director and/or Designee will conduct sample size audit of 25% of facility resident rooms monthly to ensure thorough cleaning is being completed on all floor mats. Audits will be brought to monthly QA meeting and a PIP will be entered into facility QAPI program.	

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F 279	Continued From page 8	F 279		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 279		6/19/17

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F 279	Continued From page 9 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R156) out of 27 Stage 2 sampled residents, the facility failed to develop an individualized care plan with measurable goals and interventions to address R156's urinary incontinence. Findings include: Review of R156's clinical record revealed: R156 was admitted to the facility on 8/25/16. The admission MDS assessment, dated 9/1/16, stated that R156 was frequently incontinent of urine. The CAA from the 9/1/16 admission MDS	F 279	1. R156 is no longer a resident in the facility. Her record was reviewed by the DON and RNAC. 2. The medical records of all residents with incontinence have been audited to ensure that the appropriate corresponding individualized urinary incontinence care plan is in place. All other residents had care plans in place. 3. The RNAC will now review all newly admitted residents and residents with a scheduled MDS for incontinence in the morning meeting daily and ensure the appropriate corresponding urinary incontinence care plan is in place.	

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F 279	Continued From page 10 assessment triggered urinary incontinence as a potential problem area. The facility stated they would proceed with care planning for urinary incontinence. Review of R156's clinical record revealed the absence of an individualized urinary incontinence care plan. The facility failed to develop an individualized urinary incontinence care plan for R156. During an interview on 5/2/17 at 2:32 PM, findings were reviewed and confirmed by E12 (RNAC).	F 279	4. (a) The DON will audit 10 random resident records weekly to ensure that all incontinent residents have individualized urinary incontinence care plans in place until 100% compliance is maintained for 4 consecutive weeks. (b) Then, the DON will review 10 records monthly until 100% compliance is maintained for 2 consecutive quarters. The findings will be reported in the monthly QA meeting.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan	F 280		6/19/17

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F 280	Continued From page 11 of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 280		

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F 280	Continued From page 12 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that for one (R27) out of 27 Stage 2 sampled residents, the care plan was revised by a team of qualified persons after each of R27's fall assessments. Findings include: The facility's policy entitled, Fall Management dated 3/16/16 included: Develop a plan of care which can include general and specific interventions to reduce falls risk...Implement intervention (immediate) after the fall. As the investigation continues the root cause analysis may trigger additional interventions to resident plan of care...Update the care plan and CNA communication form with new intervention. Review of R27's clinical record revealed the following: R27 was originally admitted to the facility on 01/11/2014	F 280	1. R27's care plan was reviewed to monitor that the appropriate interventions were listed on the care plan. 2. An audit of records of all residents who have fallen in the past 2 months was completed to ensure that all interventions were listed on the care plan. Care plans were updated as necessary. 3. All nurses will receive additional training on appropriate and timely fall intervention selection, implementation and care plan documentation. The training will be completed by the Staff Developer. 4. (a) The DON will complete weekly audits of all falls to ensure that all fall interventions are appropriate, timely, and listed on the care plan until 100% compliance is maintained x 4 consecutive weeks. (b) Then, the DON will conduct random audits of 10 falls per month until 100% is achieved x 2 consecutive quarters. The results of the audits will be	

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	085002	A. BUILDING _____ B. WING _____	05/03/2017

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F 280	Continued From page 13 07/17/15-The facility originally initiated a care plan that stated, Actual/Potential for falls r/t poor safety awareness, cognitive impairment. The initial approaches included: Resident to wear shoes when out of bed, double sided non skid socks while in bed PT/OT eval and assessment PRN Keep call bell within reach as resident allows Have commonly used articles within easy reach Ensure environment is free of clutter 8/28/15 - updated with offer frequent rest period 9/26/16 - updated with Toileting program 12/6/16 - Fall Risk assessment stated that R27 was a high risk for falls. 1/7/17 - Fall Risk assessment identified R27 was a high risk for falls and had a balance problem while walking A review of R27's Nursing Progress notes revealed the following: 1/7/2017 at 13:24 (1:24 PM)-A nursing progress note stated that the resident was found sitting on the floor on her buttocks in the hallway, holding her bleeding mouth. R27 sustained laceration to exterior lower lip and internal lower lip that required hospitalization. R27's bottom lip required sutures when hospitalized. There was no documentation in the care plan that it was updated/revised to reflect immediate intervention implementation after the fall to prevent re-occurrence. 1/9/17- (2 days later), The facility's post fall Verification of Investigation Report for the 1/7/17 fall, identified the following 2 triggered modified	F 280	reviewed at the monthly QA meeting.	

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F 280	Continued From page 14 interventions to the plan of care: :1) Psychiatrist's review; 2)Therapy referral (already part of the initial approaches since 7/17/15). The facility failed to update/revise the existing care plan to include a Psychiatrist review. In addition, on 1-9-17- 1/30/17,R27 was under PT's services. PT's evaluation and treatment services summary stated that Nursing was educated to supervise R27 to reduce risk of falls. The facility failed to update/revise the existing care plan to include the type of supervision that was put in place. 1/31/17 - Nursing Progress note stated that R27 at 1:25 AM was out of bed ambulating in the dayroom, lost her balance, fell to the floor hitting her head on the wall. R27 sustained bleeding from the back of her head and was sent to the hospital Emergency Room for evaluation and treatment. R27 returned to the facility with 3 staples on her posterior scalp laceration. 1/31/17 -The facility's after fall Verification of Investigation identified the following modified interventions to the plan of care: 1) therapy trialed on wheelchair; 2) Anti roll back to wheelchair and dycem initiated; 3) 1 person assist for all transfers and ambulation; 4) every 30 minute safety check; 5) continue offering rest periods. The facility failed to revise/update the care plan to include, the every 30 minute safety check according to the facility's modified interventions identified on 1/31/17 Verification of Investigation. 2/01/17 - R27's Fall care plan was updated/revised and included hip protectors on at all times;	F 280		

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F 280	Continued From page 15 2/3/17-R27's Fall care plan was edited/revised and included the intervention that R27 requires one person assist for safe transfers and ambulation and dycem to wheelchair, wheelchair with anti-roll backs; 2/3/17 -The facility identified that they will request ambulation program. The facility failed to revise the care plan to include this intervention after the 1/31/17 fall. 2/7/17 - The facility identified a nursing intervention to move R27 closer to nursing station. However, the facility failed to revise the care plan to reflect this intervention. 2/16/17- The facility identified a nursing intervention that the Resident was tried with Rolling Walker- not successful. The facility failed to revise the care plan to include this intervention. 2/17/17 -Nursing Progress note stated that R27 was on restorative ambulation program, nursing staff offer hand held assist with ambulation as able. The facility failed to revise/update the care plan for 2/17/17 to include the intervention, Restorative ambulation program. 3/30/17 at 2:57 PM- Nursing Progress note stated that a Rehabilitation staff E7 (OT) was walking towards the linen closet and observed resident ambulating towards main dining room entrance and tripped over fellow residents wheel of wheelchair and that resident softly hit the back of her head against the corner of entrance of the main dining room and slowly slid to floor. R27 did not sustain injury. 3/31/17-The Verification of Investigation Report	F 280		

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F 280	Continued From page 16 for the 3/30/17 fall identified the Modified interventions to the plan of care that stated offered helmet -refused by family. The facility failed to revise the care plan to include the intervention, offered helmet-refused by family. There was no evidence that the facility updated/revised the Fall care plan to address R27's actual falls after the incidents on 1/7/17, 1/31/17, and 3/31/17. 4/3/17- Nurse's note stated that E8 (LPN) heard a thud on the hallway and saw resident on the floor. On assessment R27 sustained hematoma on her occiput area, patient verbalized pain on palpation and was sent to hospital ER for evaluation and treatment. 4/4/17-The intervention Redirect resident to common areas as able was added in response to the 4/3/17 incident of fall. Although the facility periodically reviewed the care plan, it failed to update/revise R27's Fall care plan to include the immediate and specific modified interventions identified in their incident investigations after each fall, including the triggered additional intervention as the investigation continued. 4/11/17-R27 had an unwitnessed fall in her room and sustained Periorbital and facial trauma + lips, hematoma on right shoulder, left and right forearm, left elbow, right knee, left lower extremity and was transported to the hospital for evaluation and treatment. On 4/11/17 and 4/13/17, it was then that the facility revised R27's care plan and put in place	F 280		

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F 280	Continued From page 17 the general and specific interventions to reduce falls risk, implemented intervention (immediate) after the fall such as the Bed sensor alarm, Check placement and function every shift, Egress mattress, keep room well lit and clutter free, keep overhead light on while resident in bed, low bed, fall mat at bedside, mobility alarm to rock and go chair and rock and go chair plus restorative ambulation program. This finding was reviewed with E2 (NHA) and E2 (DON) on 5/2/17 at 1:45 PM.	F 280		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that their medication error rate was not 5 percent (%) of greater. The facility medication error rate was 6.9%. Findings include: Medication pass observations on 4/25/17 in the 400's unit, revealed the following: 1a. At 9:15 AM, E4 (RN) incorrectly administered Vitamin D3 1,000u by mouth to R141. The physician's order, dated 4/25/17, stated to give Vitamin D2 50,000u by mouth weekly on Tuesdays through 6/13/17. R141 was to start Vitamin D3 1,000u daily on 6/14/17.	F 332	1a 1. The MD was notified of the incorrect dose administration. The incorrect dose pill card was removed from the medication cart. 2. An audit of all medication carts was completed to monitor that the correct doses of medications were on hand in medication carts. The pill cards were checked against the EMAR to ensure that the doses listed on the MAR matched the pill card on hand in the medication cart. No issues were identified. 3. (a) All nurses will be required to have a medication pass observation to ensure that safety standards are observed.	6/19/17

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F 332	Continued From page 18 The facility failed to administer the correct form and dosage of Vitamin D to R141. Findings were reviewed and confirmed with E4 on 4/25/17 at approximately 2:40 PM. 1b. At 9:25 AM, E4 administered Omeprazole (also known as Prilosec) 20 mg by mouth to R24. The physician's order, dated 3/3/16, stated to give Omeprazole daily as above. Warnings on the medication label from the pharmacy used by the facility, stated, "...Take before food/meal." The Medication Guide for Prilosec (www.fda.gov/downloads/drugs/drugsafety/ucm322359.pdf) stated, "...Take Prilosec before a meal...". R24 was interviewed on 4/25/17 at 11:32 AM and stated she had breakfast about 8:30 AM. E6 (CNA assigned to R24) was interviewed on 4/25/17 at approximately 11:40 AM and stated that R24 ate around 8:00 to 8:15 AM and was finished eating breakfast about 8:30 AM. R24 was given Omeprazole approximately 1 hour after she ate breakfast, not before a meal as per the facility's pharmacy warning and the FDA's (Food and Drug Administration) guidance. Findings were reviewed with E4 and confirmed during an interview on 4/25/17 at 2:40 PM. During the medication pass on 4/25/17 in the 400's unit, 2 medication errors occurred which made the med error rate 6.9% out of 29 opportunities.	F 332	(b) The nurses will receive education on and be observed for correct technique during medication pass including the "7 rights" (right patient, right time, right medication, right dose, right route, right indication and right documentation). The education and observations will be completed by the Staff Educator/Designee. 4. The DON/Designee will complete 5 random medication pass observations per week until 100% compliance is achieved x 4 consecutive weeks. Then, 10 medication pass observations will be completed monthly until 100% compliance is maintained x 2 consecutive quarters. The results of the audits will be reviewed at the monthly QA meeting. 1b 1. MD was notified about R24's preference to receive Omeprazole after breakfast and the following order was obtained, "Ok to give Omeprazole after breakfast at residents preference." 2. All residents receiving Omeprazole and all other Antiulcer/Proton pump inhibitors were audited to monitor that the medication was being given prior to meals. The medication administration times were changed where appropriate. 3. (a) All nurses will be required to have a medication pass observation to monitor that safety standards are observed. (b) The nurses will receive education on and be observed for correct technique during medication pass including the "7 rights" (right patient, right time, right medication, right dose, right route, right	

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F 332	Continued From page 19	F 332	indication and right documentation). The education and observations will be completed by the Staff Educator/Designee. 4. The DON/Designee will complete 5 random medication pass observations per week until 100% compliance is achieved x 4 consecutive weeks. Then, 10 medication pass observations will be completed monthly until 100% compliance is maintained x 2 consecutive quarters. The results of the audits will be reviewed at the monthly QA meeting.	
F 389 SS=D	483.30(d) PHYSICIAN FOR EMERGENCY CARE, AVAILABLE 24HR (d) Availability of Physicians for Emergency Care The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (R27) out of 27 Stage 2 sampled residents, received the services of a physician 24 hours a day in case of an emergency. Findings include: Review of R27's clinical record revealed: 1/31/17 at 1:35 AM- Nurse's progress note stated that at 1:25 AM, R27 was ambulating in the dayroom, she lost her balance and fell to the floor hitting her head on the wall. R27 was noted to be bleeding from the back of her head and pressure was applied to the area. Attempted to call on call physician, left message on answering machine,	F 389	1. The incident on 1/31/2017 was reviewed by the facility Medical Director and DON. 2. An audit was completed on MD call back times to ensure timely return calls by MD/NP. All attempts to contact MD/NP in the past 30 days have been timely with no lapses in call back time identified. 3. The facility Medical Director has provided an on call schedule to the facility as well as her personal cell phone number to staff nurses to use in the event that they are unable to reach the on call MD/NP. 4. The DON/Designee will complete an	6/19/17

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F 389	Continued From page 20 no return call, called 3 additional times with no answer. R27's daughter was notified of the event and gave the OK to send resident to the ER despite R27 had no hospitalization restriction on Palliative care assessment. On call nurse was notified and stated to send resident to the ER. 911 was called at 1:34 AM. R27 was transported to the hospital ER . 1/31/17 at 07:00 AM-R 27 returned to the facility from the hospital with diagnosis of posterior scalp laceration with 3 staples and was also given Haldol medication in the emergency room. 5/2/17 at 8:30 AM-During an interview with E13 (LPN), she stated that the NP(E3), who was taking call for the physician, did not return the call. DON (E20) and the physician was made aware. This finding was reviewed with E1 (Administrator) and E2 on 5/2/17 at 1:45 PM.	F 389	audit of turn around times for on call MD/NP notification. Ten random audits will be conducted weekly on calls to the on call MD/NP to ensure that calls are consistently returned timely x 4 consecutive weeks. Then, 10 random audits will be conducted monthly until calls are returned timely x 2 consecutive quarters. The results of the audits will be discussed with the team at the monthly QA meeting.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

FACILITY: Parkview Nursing

DATE SURVEY COMPLETED: May 3, 2017

	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from April 25, 2017 through May 3, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 140. The Stage 2 survey sample size was 27.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed on May 3, 2017: F225, F253, F279, F280, F332, F389.	CROSS REFERENCE CMS 2567-L	6/19/17

Provider's Signature _____ Title ADA Date 5/25/17